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DEPARTMENT OF MINES

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SUMMARY OF FATAL ACCIDENTS AT ONTARIO MINES, METALLURGICAL WORKS, QUARRIES, AND CLAY, SHALE, SAND AND GRAVEL PITS, DURING NOVEMBER, 1959

There were six fatal accidents, each causing the death of one man, during November. Included also is the verdict of an inquest covering the death of E. J. Laasanen which occurred during June.

MINES

LAKE SHORE MINES, LIMITED

Stoel Bentley, British, aged 49 and married, was killed in a rush of sand fill in the 5505E1-1 Stope at the Lake Shore mine on November 3, at about 1.30 A.M.

The inquest on this accident has not been held and the report covering this accident will be published at a later date.

MacLEOD-COCKSHUTT GOLD MINES, LIMITED

Nick Bewcyk, Romanian, aged 57, and married, was injured when his right foot was crushed between the side of a six ton Goodman trolley locomotive and a dumping ramp at the 1050 south ore pass on the 11th level of MacLeod-Cockshutt Gold Mine at approximately 8.20 A.M. on November 2.

Bewcyk was taken to the Little Long Lac Hospital and while being given anaesthetic during treatment his heart stopped. The doctors opened the chest and were successful in starting the heart. The injured man did not regain consciousness and died at 2.00 P.M. November 5. The injury to his right foot consisted of lacerations to the heel and dislocation of some of the bones of the foot.

Bewcyk was an experienced miner with over twenty years underground. He had worked at MacLeod-Cockshutt off and on since 1939. His last date of employment being in 1950. For about six months he had worked as motorman on the 11th level and was familiar with the dumping arrangement at the 1050 south ore pass. At the time of the accident he was working with the underground mechanic on car maintenance.

On the 11th level, ore is transferred from the No. 1 shaft to the No. 2 shaft where it is dumped at the 1050 south ore pass, from which it goes to an underground crusher and then hoisted to surface. The haulage train consists of a six-ton Goodman trolley locomotive and a four-ton Granby type car. The dumping arrangement consists of a ramp on which a wheel on the box of the car rides causing the car to tip and dump its load. The ramp is hinged at the bottom so it can be swung down flat with the drift floor to give clearance when other types of cars are used.

On the day of the accident, Bewcyk and Shinji Fukushima, underground mechanic, were to grease cars on the 13th level, No. 1 shaft.

They went to the machine shop on the 11th level, which is located at No. 2 shaft station, and only a few feet from the ore pass, to pick up their tools, grease gun, etc. A train operated by E. Veito had completed dumping a load of ore and was about to start back to No. 1 shaft, which is a distance of about 1700 feet. They loaded their equipment on the locomotive, and Bewcyk and Fukushima sat on the front of the locomotive, which was facing the first car. Bewcyk was on the right side nearest to the ramp.

This type of locomotive has a step at the front end, about one foot wide, running across the width of the motor and was used as a foot rest by the men.

The locomotive started and had moved only about 10 feet and was passing through the ramp at very slow speed when Bewcyk called to Veito to stop. The motorman stopped immediately and it was found that Bewcyk's right foot was jammed







between the side of the locomotive and the dump ramp. The distance travelled by the locomotive after Bewcyk's foot was caught was five and a half feet. The space between the motor and the ramp was about 3 inches.

The ramp was swung down and Bewcyk was released. C. Boiven who was working near by immediately called the No. 2 shaft cage and went to surface and notified the first aid man then returned to the scene of the accident with a stretcher and blankets. Bewcyk was brought to surface, where Dr. Malcolm was waiting with an ambulance, and immediately taken to the Little Long Lac Hospital.

An inquest into the death of Nick Bewcyk was held in Geraldton at 4.00 P.M. November 24, with Magistrate T. A. Connor acting as Coroner, and Crown Attorney P. V. Ibbetson in attendance.

Dr. A. H. Malcom gave evidence that injuries to Bewcyk from the accident consisted of a mid-tarsal dislocation, lacerations and fractures in the small bones of the right foot. He said that death was due to brain damage due to oxygen starvation during the time that the heart stopped beating. Dr. W. R. Wardill, anaesthetist, stated that the anaesthesia was an extremely difficult one.

The verdict of the jury was as follows:

"We, the Jury, find that Nick Bewcyk came to his death at 2.00 P.M. on November 5th, 1959 at Geraldton. We, the Jury, agree the cause of death of Nick Bewcyk was cardiac arrest. We believe this condition caused from an injury received on November 2nd, 1959 at MacLeod-Cockshutt Mine with no blame attached to anyone."

#### PAMOUR PORCUPINE MINES, Limited

Robert Emerson Woodward, cagetender's helper, Canadian, aged 25, and single, was killed when he fell from the cage into the No. 3 Shaft of Pamour Porcupine Mines at 8.45 P.M., November 11. Woodward was an experienced cagetender. He had been employed at Pamour in various capacities on surface and underground during his summer vacations from school every year since 1950.

No. 3 Shaft at Pamour extends vertically from surface to 26 feet below the 3100-foot level. The 6 by 9 foot cage compartment occupies the north end of the shaft excavation. The long axis of the shaft lies north and south — the long axis of the cage compartment lies east and west. All shaft stations and the cage are so arranged that the cage can be loaded or unloaded from either end. Shaft sets are of 10 by 10 inch B.C. fir, 6 feet high and are tight lined outside the timber next to the wall rock.

At the time of the accident, Woodward and cagetender Rudolf Rieck were removing a three-ton tippie type car loaded with gravel from No. 3 Shaft Cage at the 2900 Level Station. Cagetender Rieck had chaired the cage and he and Woodward were pushing the car out the west end of the cage onto the level. The two men had their backs against the east end of the car. The wheels on the west end of the car were out of the cage and the car was moving. The wheels on the east end of the car were still on the cage when the cage chairs slipped and the cage fell a distance of about 10 1/2 feet. The loaded car tipped back and fell into the cage and about half of the load of gravel spilled over the east end of the car onto Woodward and Rieck. Woodward fell or was knocked down and covered with gravel. Rieck fell to a sitting position and was buried up to his chest. His left leg was doubled under him with his knee projecting out of the open cage door and under a shaft wall plate. He was wedged in this position and could not get free. He called for help and the carpenters working in the nearby Crusher Station heard him and came out to investigate. Leo Aro, the carpenter foreman, saw the shaft doors open and the top of the cage about 2 feet below the station floor. He lifted the hinged cage roof to investigate and saw Rieck pinned between the car and the wall plate but saw no sign of Woodward. Rieck did not know what had happened nor where Woodward was. Aro phoned the hoistman, explained Rieck's position and discussed a plan to release him. Aro then climbed down into the cage, tied a rope around Rieck, and rang the cage down sufficiently to release Rieck's leg. The men on the level pulled on the rope and freed Rieck from the gravel. At this point the pile of gravel around and under the pinned man started to run into the shaft. The men on the level saw a leg and boot go with it. Unknown to the men helping Rieck, Woodward had been buried under the gravel. Moving the cage and Rieck's struggles to free himself caused the gravel to run through the 12 1/2-inch opening between the east end of the cage floor and the tight lining of the second set below the 2900 Level. Woodward went with the gravel and fell a distance of 242 feet to the bulkhead over the shaft sump. He was dead when help reached him. It is not known whether he died from injuries received in the cage or from those



University of Toronto



sustained in the fall.

The cage chairs consist of four steel legs that hang vertically under the cage, one in each corner. The legs are connected together by a system of shafts and levers and are raised into position for chairing by the cagetender from outside the cage. The cage is raised a foot or so above the station floor and a chair operating lever under it is caught and raised by means of a long hook. This extends the legs. The cage is then lowered onto them. The chair legs fall free automatically as soon as the weight of the cage is lifted off them. The legs turn out through an angle of 33 degrees in an east and west direction and engage angled steel bearing plates set on bevelled bearing timbers placed horizontally between the cage compartment posts, 1 foot 8 inches below the station floor. The 2 by 3 inch by 1 foot 1 inch long legs are so designed that the whole cross section area should bear on the bearing plates. If the legs were fully extended when set and the mechanism and bearing plates were in proper adjustment, the legs would have to move inwards more than 3 inches to slip out of position and release the cage. The design of the chairs is such that the weight of the cage and load acts to extend the legs when the cage is chaired and not retract them.

The cage and mechanism were examined after the accident and found to be in perfect order. The bevelled bearing timbers at each end of the compartment supporting the steel bearing plates were not in their proper position, however. The timbers had spread due to the wedging action of the cage on the bearing plates when chaired. The four bearing plates were 2 5/16 inches, 2 1/16 inches, 2 3/8 inches and 2 1/16 inches out of position and resulted in the four legs being able to bear 7/16 inch, 11/16 inch, 3/8 inch and 11/16 inch on the plates instead of a full 3 inches. There was very little horizontal play between the cage and the guides at this point but the operating clearance present could act to decrease the chair leg engagement at one end of the cage and increase it at the other.

The chair seats at every level on the shaft were checked and they were all out of position by varying amounts. None were as widely spread as those on the 2900 level.

Steel tie rods with turn buckles have been installed between each pair of bearing timbers in the shaft to draw them into position and hold them there. The distance between each pair of bearing timbers is being measured once a week by the shaft inspectors and a note to that effect is being made in the Shaft Inspection Record Book. Also, the design of these particular chairs is being investigated with the thought in mind that they possibly could be changed so as to remove the horizontal thrust that tends to spread the bearing timbers and plates.

An inquest was held before Coroner J. B. McClinton, M.D., in the Municipal Building of the Township of Whitney at 4.00 P.M., on November 27. The jury arrived at the following verdict:

"We the jury find that Robert Woodward came to his death in the Pamour Mine on Wednesday November the 11th at 8:45 p.m. in a fall down 3 Shaft from the 2900 foot level to the bottom of the shaft, a distance of 200 feet. Death was due to a broken neck — cause of accident due to spreading of timbers support (sic) the cage chair seats. No blame attached to anyone at scene of the accident.

"We recommend that a thorough examination be made of the chair seats and the distance between the chair seats be measured once a week, also that shafts where men are hoisted by tight lined."

#### CANADIAN DYNO MINES LIMITED

Paul Nemeth, aged 30, Hungarian, single, was fatally injured at about 3.15 P.M., November 21, as a result of a fall in 3A-7 stope at Canadian Dyno Mines Limited.

Nemeth was hired as a helper on March 30, 1959 and had been promoted to a machine runner on May 14. His only other mining experience was 6 months at the Sylvanite mine.

The 'A' ore zone is about 4,000 feet north of the main shaft. Among other stopes in this zone, the 3 A-7 stope was developed with 7 chutes. It was mined shrinkage from 2 cribbed manways to a height of 140 feet above the track, and at this point it was stopped to draw the muck. This stope averaged 165 feet in length.







This ore body strikes almost due north-south, the hanging wall averages 66 degrees east in dip and the rake is vertical. Widths remained relatively narrow for the first 90 to 100 feet in height then the ore widened out to the west or foot wall side to 30 or 40 feet. This widening developed a bench along the west side from the south end to within 25 feet of the north end. The south manway was carried up along the north side of No. 3 chute and the north manway along the south side of No. 7 chute. In No. 1, 4 and 6 the chutes were removed and these draw points were transformed to handle the muck with mucking machines. Most of the muck was being drawn from these three points.

The pulling of this stope on a salvage basis started about the middle of October and it was the intention to support the walls as the muck was being cleaned down. At the south end, it became increasingly difficult to hold the hanging wall and it was decided to abandon the cleaning down on the south side of the south manway. On November 14, a large piece of loose sluffed off the hanging wall in this section, about 25 feet south of the manway, settling on the muck below the bench. Later as the muck was pulled this large rock wedged between the walls.

On November 21, Nemeth and his partner, Marcel Lachaine, were instructed by their shift boss, Bill Honeywell, to continue barring muck where No. 4 and 6 were pulling. There were 3 mucking machine crews loading from No. 1, 4 and 6 on this shift.

The muck in the stope at this time, between the manways and to the north end, was pulling along the hanging wall and was down in places to where the bench was being exposed. The muck was being kept scaled down to an angle of 40 to 50 degrees. While working on this muck pile a 1 inch rope was attached along the west wall at the top of the slope of the muck, from which were attached other ropes, with which the men supported themselves. The 1 inch rope along the west wall extended from the north end to a point just south of the south manway. The muck in the south end of the stope had been pulled down about 9 feet below the bench at the south manway and then sloped to the south towards No. 1 draw point (under the big rock wedged between the walls).

Honeywell on his second trip into this stope at about 2.30 P.M. found his crew working opposite No. 4 and 6 draw points, and both had separate ropes tied round their waists. On the foot wall of the stope opposite No. 4 draw point, just above the line of the muck, Honeywell found quite a large piece of loose. After trying it with a scaling bar, he told nemeth that it should be rock bolted and instructed him how it should be done. As it was getting close to the end of the shift (8.00 A.M. - 4.00 P.M.) and in view of the fact that this same crew would be the next to return to this stope on Sunday night shift, Honeywell told them they could leave it until they came on shift Sunday. He also instructed them to keep away from this part of the stope for the balance of the shift. He further instructed Nemeth to take one of the 3 drill machines out of this stope.

During this shift the 3 mucking machine crews pulled 37 tons from No. 1, 112 tons from No. 4, and 34 tons from No. 6.

Blasting time for the mine was set at 3.40 P.M. and a start was made to hoist the men at 3.50 P.M. Honeywell had checked all his crew out except the two men in 3 A-7 stope. After checking the 'in and out' board, he phoned the cagetender at about 4.30 P.M. The cagetender was on the 3rd level station and he reported that Lachaine had just arrived on the station and was quite badly injured. He also reported that Nemeth was still in the stope. Lachaine was brought to surface and attended by the First Aid man until Dr. A. V. Lehinant arrived with the ambulance from Bancroft at about 5.00 P.M. Lachaine suffered from numerous injuries and shock. Dr. Lehinant returned to Bancroft with Lachaine in the ambulance.

A rescue crew, led by shift bosses W. Honeywell and V. Dubois, included miners C. McKellar, S. Hegedus and F. Bryla. They searched the north end of the stope then moved to the south end. Honeywell thought there had been a run of muck off the bench just south of the south manway. Two men had started to shovel muck in this area when Dubois noticed some blood, then Nemeth at the toe of the muck pile. He was below and south of the large rock mentioned above, in the extreme south end of the stope. There was very little muck on him. Severe head injuries were evident and no pulse could be detected. He was removed in a stretcher and brought to surface at 6.15 P.M. Coroner O. W. Anderson examined Nemeth in the First Aid room at 6.30 P. M. and pronounced him dead.

Dr. J. H. Whiteside of Peterborough performed an autopsy in the Civic Hospital, and direct cause of death was attributed to fracture of the skull and contusion of the brain.







From the evidence presented at the inquest, Lachaine, who needed an interpreter, was the only eye witness to this accident. He testified that they had removed their ropes and were moving some gear, a drill machine included, that was lying at the top of the slope of the muck pile, against the west wall and opposite the south manway, when the accident occurred. He thought some loose had fallen, he did not know from where, and that it caused the muck on which they were standing to slide, and they went with it. They were standing 8 feet apart, and Nemeth fell first. After falling, Lachaine retrieved his hat and his light was still intact. He claimed that he did not see his partner but that he could hear him breathing. He made his way out of the stope by way of the south manway. He also stated that the accident occurred soon after the shift boss had left the stope.

The inquest was held before Coroner O. W. Anderson, M. D., in the Ontario Provincial Police Court in Bancroft at 7.00 P.M., on December 16. The jury presented the following verdict:

"We find that Paul Nemeth, the deceased person, came to his death at approximately 3:15 o'clock in the afternoon on the 21st day of November, 1959 at Canadian Dyno Mines in 3A-7 stope and that death was caused by fracture of the skull and contusion of the brain, the result of a fall caused by a run of muck down the stope. Accidental death.

"We, the jury, recommend that safety ropes be attached to the workmen and the life line at all times in this type of work."

#### NORTHSPAN URANIUM MINES, LIMITED - Lacnor Mine

Jean Florian St. Jean, grizzly labourer, aged 22, Canadian, single, was fatally injured while breaking rock on a grizzly in Northspan Uranium's Lacnor Mine at 9.50 A.M. on November 25. No previous underground experience is listed on his employment record. It is understood, from hearsay, that he had worked underground at Timmins, Ontario.

The scene of the accident in the 3-1 W drift was the ore and waste pass dumps which are about 34 feet apart. Alex Suzack and Jean St. Jean were the grizzly-men working there on day shift, November 25. At the time of the accident, St. Jean had a half dozen medium sized chunks of waste rock to break and pass through the grizzly. Suzack had just finished clearing chunks from the ore pass grizzly and had started to walk towards the waste grizzly when he realized something was wrong. St. Jean had stepped off the grizzly, put down his 14 pound hammer, and was unhooking the life line from his safety belt. He called out, "I've broken my windpipe". Two shift bosses, Donald Hutchinson and Colin Macaulay, were talking together about 30 feet away and also heard St. Jean call out. The 3 men hurried to his assistance and placed him on a lunch bench nearby. A call was put through to alert first aid on surface from the shifters' office. A service truck was quickly procured and St. Jean was taken to the first aid on surface within fifteen minutes of the accident. During the short interval before the truck arrived Suzack said to his partner, "Don't talk. Nod your head. Did a piece fly off the rock and hit you?". St. Jean nodded in the affirmative. Then he immediately said, "I can't breathe". Suzack took off the man's hat, head light, and belt; then opened his shirt. He was coughing up a great deal of blood and froth.

Dr. J. P. Moody had been called, but had not reached the property when St. Jean arrived at first aid on surface, so the patient was immediately taken by ambulance to Elliot Lake Hospital. He was examined there by Dr. R. D. Smith, within thirty minutes of the accident, but had apparently died during the short ambulance trip to the hospital.

In the absence of Coroner M. J. Farrell, M. D., Coroner J. A. Pigeon, M.D., of Blind River issued the warrant for taking possession of the body. Dr. Geoffrey Mizbah, at the request of Dr. Pigeon, made an autopsy which included x-rays of the victim's neck prior to dissection. Dr. Mizbah concluded that a small sharp object had penetrated the neck in the area of the carotid artery, jugular vein and vagus nerve. Although Dr. Mizbah was unable to probe from the outer laceration to the small neat hole in the trachea, he discerned a gritty path through the neck muscle on the x-ray plates. He felt that the flesh of the neck muscle had closed in to obscure the small hole. Dr. Mizbah attributed death to a combination of asphyxia, due to the upper third of the lung cavity being full of blood, along with heart stoppage effected by the vagus nerve.

Dr. Pigeon decided that there was sufficient grounds to suspect foul play and







in collaboration with Chief Constable J. S. McLaren an investigation was instigated. This investigation proceeded during the night of November 25 and a second autopsy was performed by Dr. T. W. Whang, in the presence of police officers, the following day. Dr. Whang demonstrated that a probe would not pass through from outside wound to inside wound. He also removed the trachea and decided that the inner wound was a tear between ring cartilages. He concluded that the victim had been struck by a blunt object which caused internal haemorrhaging into the windpipe. Cause of death was attributed to asphyxia from the victim's own blood.

At the inquest held on December 26, before Coroner M. J. Farrell, the jury returned the following verdict:

"That Jean Florian St. Jean came to his death at 9:50 in the forenoon of the 25th day of November, 1959, and that death was caused by accidentally sustaining a blow to the throat by some object while breaking rock on the grizzly."

### CLAY PIT

#### NATIONAL SEWER PIPE, LIMITED

Klymens Gzeckowski, Polish, aged 65, married, received critical injuries about 10.00 A.M., November 19, that caused his death November 29, about 6.30 P.M. He was hired April 30, 1945 by National Sewer Pipe Limited, and was classified as a labourer. He had worked continuously with the Burlington division performing duties of an axeman, brusher, slasher, and utility man ahead of the actual mining of the clay.

National Sewer Pipe Limited employ about 6 men, and operate clay pits in Burlington for subsequent transfer to their processing plants in Clarkson and Hamilton. The workable land is cleared of trees; the wood is salvaged for heating purposes; the brush is burned; and the clay is removed to a depth of about 3 feet by a Diesel International T.D. 14, drawing a Letourneau scraper. The trees greater than 4 inch diameter are cut about 4 feet above the ground and the stumps are left standing for subsequent removal by the dozer. The area of smaller growth is cleared by hand. The scraper discharges the clay to a stock pile where an end loader is used to load the cartage trucks. Roots and foreign debris in the stock pile are removed periodically.

On the morning of November 19, the victim and the T. D. 14 dozer operator were instructed to remove in the conventional manner the logs from an area located about 3/4 mile away from the current pit which was being prepared for future mining operations. These two men, in the normal course of their duties, placed a hitch near the front end of a pile of logs situated at the bottom of a ravine. The bulldozer was positioned about 120 feet away at the top of the hill. The 1/2-inch diameter cable of the winch installed at the rear of the T.D. 14 was attached to the hitch and drawn taught. A signal was given by the victim to the dozer or winch operator to pull the logs up the slope. During this manoeuvre, unobserved by either employee, the logs collided with an upright 4 foot high stump that swung one log within the pile in an arc, pivoted about the hitch. The log struck Gzeckowski on the side of the head, knocking him to the ground unconscious, about 20 feet from the path of the logs. The time was about 10.00 A.M.

The partner of the victim, Bruno Gaspari, ran about 3/4 mile to summon help. When additional men and a truck returned, the victim was walking about in a slightly confused condition. He was driven immediately by Arthur Frizzo to the St. Joseph's Hospital, Hamilton, where he was attended by the hospital staff and Dr. W.A. Weaver, Burlington. P. C. Thompson and Detective George Moore of the Burlington Police Department investigated the accident.

An autopsy was performed on the deceased at St. Joseph's Hospital by Dr. Murray Mink and Dr. Haager of the staff of the Provincial Pathologists. The injuries were reported as follows: a fracture to the right side of the skull and concussion.

Cause of death was:- an embolus in the right and left pulmonary arteries and a fracture to the right side of the skull.

Dr. R. T. Dingle, Coroner, and Mr. Peter McWilliams, Crown Attorney, will decide time, date and place of inquest.







GROUP V11

MACKLAIN CONSTRUCTION COMPANY

Gordon Phillips, Canadian, aged 49, and married, was fatally injured about 10.15 P.M., November 24, while riding runaway railway cars at Depot Harbour. He died the same day at 11.50 P.M., in the Parry Sound General Hospital.

Phillips was employed by Macklain Construction Company of Parry Sound and had worked for eight days as brakeman on the unloading of railway cars for Lowphos Ore Limited. Lowphos ships iron ore concentrate from their mine near Capreol by Canadian National Railway to Depot Harbour, Parry Sound.

The strike settlement of the steel industry in the United States, late in the shipping season created an urgent demand for iron ore concentrate. It was necessary to divide the normal Lowphos unloading crew of eight men, working an 8 hour day shift under Orville Dool, into two shifts working 12 hours. The extra men, as required by Lowphos, were supplied by Macklain Construction Company.

The unloading installation at Depot Harbour is used to unload the iron ore concentrate from railway cars and convey it either to stockpiles, or directly to ships. It consists of a section of double track to park loaded cars coming from the mine. The double track is reduced to a single track through the car unloader installation, then widens out again to double tracks to permit the storage of empty cars. The grade of the tracks at 1.16 percent is sufficient for a parked loaded car, given a start with car jacks, to continue through the car unloading installation to the empty car storage area where the tracks ended. The empty car tracks are connected to another track parallel to the unloading installation, which permits the Canadian National yard engine crew to remove the empty cars. The car unloader installation contains a bottom dump car unloader arrangement with overhead vibrating car shaker.

The Canadian National crew had delivered 49 loaded cars about 4.15 P.M., November 24, the day of the accident. 27 cars were parked on one track and 22 on the other. The night shift crew was made up from 3 Lowphos and 10 Macklain men starting work at 3.00 P.M. under Delbert Harris. The weather was windy with intermittent showers. The crew had completed the unloading of the 27 cars parked on one track and one from the other track about 10.00 P.M., when the accident occurred.

Three men were unloading the second car. The third and fourth cars were parked near the unloader, with the remaining 18 further up grade where they had been parked by the train crew. Two men, Robert Koomans and Fred Rand were bailing water from the third car, while Gordon and Danny Phillips were about to bring it to the unloading area. Bob Cormican assisted by Rod Currie and Mervin Robinson were bringing the loaded cars one at a time to the unloading area. Cormican decided Gordon Phillips was ready to move the third car into the unloader and climbed up to the brake platform of the fifth car. Currie and Robinson released the air brake pressure and opened the coupler between the fifth and sixth cars. Cormican partially released the handbrake and the use of the car jacks started this car downgrade toward the unloading area. As the fifth car moved away the remaining 17 began to follow. Currie thought a locomotive was pushing them until alerted by Robinson. Currie climbed up to the brake platform of the sixth car and applied the handbrake. When Cormican heard and saw Currie he applied the handbrake on the fifth car that he was riding. Currie and Cormican unable to stop the 18 loaded cars, jumped off just before they reached the unloader.

The men at the unloader saw the 18 cars approaching and shouted. The car shaker was operating and drowned out the shouting. All men in the area were able to reach safety excepting Koomans and Gordon Phillips. Koomans lay down on the concentrate in the third car as it was bumped and pushed forward to strike the second car. He passed safely under the hanging car shaker and on looking up saw Phillips at the handbrake of this car. The 21 cars were now together and running towards 5 empty cars parked at the end of the line. Koomans went to Phillips and asked him if the train would stop. Phillips told him to apply the handbrake on the following car. Koomans did this, then jumped off as he felt the bump of the leading car striking the empty cars parked near the end of the tracks.

It is not known if Phillips thought of jumping or was still hopeful of stopping the runaway cars. The collision of the runaway train with the parked empty cars, at about 10.15 P.M., broke the car stop at the end of the line allowing the cars to go off the end of the track and pile up.







Gordon Phillips was found by several of the crew hanging by his safety belt which had been snapped to the ladder rung. He had been crushed between the cars during the pile up. He was removed and while awaiting the ambulance he was conscious and spoke only of his discomfort. Dr. Weakley and the ambulance crew removed Phillips to the Parry Sound Hospital where he died of a crushed chest at 11.50 P.M.

An explanation of the cause of movement of the 17 cars was not found but some pertinent facts were disclosed. Definitely, the lack of sufficient railway experience contributed to the accident. The Canadian National Railway crew testified that the air brakes on all 22 cars and the handbrakes of 8 cars on the down grade end, were put on when the cars were parked in the afternoon. A test on the loaded cars was made after the accident by the railway company. The air brakes were found to hold over an equivalent length of time that had elapsed prior to moving the parked cars on November 24. It has been found that almost every single car which had been moved by Lowphos men needed jacking to start it moving. It was claimed to be possible for the coupled 17 loaded cars with all brakes off to be started into movement by the vibration of a locomotive moving cars on the parallel track. Cormican relied on the air brakes and had not taken precautions to see that enough handbrakes were on. There should have been three cars with handbrakes still on, out of the 8 which had been put on by the engine crew. It appears that someone had released the brakes of the remaining loaded cars. On examination of the brake pawls of all the cars after the accident, only 3 cars, one parked empty car, the second car, being unloaded, and the fifth car had indications that the handbrakes had been applied. The fifth car, braked by Cormican, had flattened spots on the wheels.

The unloading operation continued for a few more days to the end of the shipping season with the use of a locomotive for moving the loaded cars to the unloader.

An inquest was held before Coroner A.J.L. Wright, M. D., at Parry Sound on the evening of December 9. The jury returned the following verdict:

"We the Jury have come to the decision that the cause of death 'Gordon Phillips', was caused by being crushed between run-away ore cars on the night of November 24 - 1959 between the hours of 10 and 11:50 P.M. (died at the Parry Sound General Hospital at 11.50 p.m. November 24th 1959) at the Lowphos Ore Limited at Depot Harbour on the Parry Island Indian Reserve in the District of Parry Sound. Such accident being caused by negligence by parties concerned. Therefore the Jury recommend that brakes on all cars spotted, be inspected by parties concerned to see that brakes are properly set on all cars before any attempt is made to move them for unloading purposes or other safety precautions taken. This we feel would prevent any future accidents of this nature happening."

**THE FOLLOWING IS THE VERDICT OF THE INQUEST HELD AT COMMUNITY HALL, FALCONBRIDGE COVERING THE DEATH OF EERO JOHANNES LAASANEN:**

"That Eero Johannes Laasanen, age 35 y. address 466 Eva St., Apt. 5, Sudbury, motorman, died June 11th/59 at 2:45 A.M. in Emergency Room St. Joseph Hospital of crushing injuries of the thorax received in drift 808 -140-150 proximity of 5 chute, level 825 - 1200 ft. in shaft No. 1 of Falconbridge East Mine, June 10th, when he was caught between the chute stand and the moving ore car.

"From the Evidence of all witnesses, I find his death accidental with no blame attached to any employee or employer."







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ONTARIO  
DEPARTMENT OF MINES

SUMMARY OF FATAL ACCIDENTS AT ONTARIO MINES, METALLURGICAL WORKS  
QUARRIES AND CLAY, SHALE, SAND AND GRAVEL PITS, DURING JANUARY 1960.

MINES

Kerr-Addison Gold Mines, Limited

Armand Gerard Robidas, Canadian, aged 23, and single, was killed by a fall of rock in 3421-66 stope at the Kerr-Addison Gold Mines, Limited on January 30.

Robidas had worked at the Kerr-Addison Mine from August 1955 to March 1956. He was re-hired in December 1959 as an apprentice miner.

3421-66 stope is a cut-and-fill stope, and at the time of the accident the elevation was 65 feet above the 3400-foot level. The stope varies from 15 - 45 feet in width and is 240 feet in length. The stope is serviced by two manways and there are two concrete mill holes for removing broken muck by means of slushing. A stope raise extends through to the level above and at the time of the accident mining had proceeded about 100 feet east of this raise.

On the day shift of January 30, Robidas and Jacque Millette, apprentice miners, and H. Pleau, stope leader, worked in 3421-66 stope. The stope back was scaled and then Robidas proceeded to drill short holes on the north side of the stope while Pleau slushed ore into the mill-hole. Shift boss R. G. Wilson visited the stope at approximately 11.00 A.M., and checked the working place. He instructed Pleau to blast 11 holes in the north side and then go for lunch. Wilson also instructed the men to scale the back after lunch, and then rock bolt the back on the north side, and drill a breast east on the south side.

The stope crew returned from lunch at 12.45 P.M., and Pleau and Robidas scaled the back at the north side while Millette proceeded to drill on the south side. Pleau states that they had finished scaling and checked the back. He was checking the breast for missed holes when two pieces of loose approximately 4- by 6-feet by 6-inches fell from the back. One piece struck Robidas and pinned him in a doubled up position. He appeared to have been killed instantly. Pleau and Millette were able to pry up on the flat piece of rock and release Robidas.

An examination of the back after the accident showed that there were no slips or faults in the vicinity. Pleau stated that he had sounded this particular spot and had considered it sound. He also stated that he had heard a snapping or cracking just before the loose fell.

Dr. A. S. McPhail proceeded underground at approximately 1.30 P.M., and pronounced Robidas dead. The doctor stated that death was probably instantaneous and was caused by a cerebral hemorrhage due to skull fracture.

An inquest was held before Coroner J. F. Edis, M.D., at the Municipal Hall in Virginiatown on Wednesday, February 3, 1960 at 7.45 P.M. The jury returned the following verdict:

“That Armand Robidas came to his death on January 30, 1960 at Kerr-Addison Gold Mine, Ltd. in 3421-66 stope. Death caused by skull fracture due to falling rock.”







Hollinger Consolidated Gold Mines, Limited

Joseph Elie Paquette, Canadian, aged 21, single, stope helper, employed in various capacities underground at Hollinger Mine since May 28, 1957, was buried by a run of muck in the No. 31 millhole of 121 north heading west of 11.3 cut-and-fill stope on the 1850-foot level of Hollinger Mine at about 10.05 A.M., January 30. He died at about 3.15 P.M. the same day just as he was being released. Dr. R. N. Bissonnette was present at the time of death and had been for several hours during the rescue operations.

121 north heading west of 11.3 on the 1850-foot level of Hollinger Mine is a stope shaped like the capital letter "W". The left hand or south half of the W is being mined as a conventional shrinkage stope. The north half is a "V" shaped cut-and-fill stope. The accident herein described occurred in this north section.

The cut-and-fill section is about 90 feet long in an east-west direction, 7 feet wide from foot to hanging wall, and had been mined up 22 feet above the back of the 1850-foot level. A 15-foot depth of sand fill was in place over the drift timber. Three stilled boxholes were established and carried up through the fill; a cribbed manway was constructed alongside each. No. 31 millhole is at the extreme east end of the stope. At the 15-foot elevation ore was encountered in the east-end-wall, and a stope drift was driven east along it a distance of 60 feet. From this drift a raise was driven up to the 1700-foot level. A new cut was established at the raise and the breast was advanced westward in the stope over and past No. 31 millhole. The new silled area was mucked out, a timber barricade erected just east of No. 31 millhole. A 7-foot layer of fill was placed from the barricade to the extreme east end of the stope. A drift was being driven from this fill to the northwest along an ore stringer in the hanging wall. This drift was collared about 5 feet to the east of No. 31 millhole. The muck from the drift was scraped out with a slusher and it ran down the timber barricade into the millhole. For a few days prior to the accident the millhole had been completely covered with several feet of muck from this drift.

On the night shift of January 29, Edgar Perron, acting stope runner, and his partner worked in the shrinkage stope section of 121 north heading west of 11.3. At lunch time the men reblasted 5 holes in the face of the drift. To reach the drift they had to climb over the muck pile which covered No. 31 boxhole. At this time it was perfectly safe to do so. After lunch, Shift Boss W. Cotnam inspected the stope and then instructed the motor crew on the 1850-foot level to pull No. 31 millhole. The crew did this until, after 8 cars had been loaded, the muck in the millhole hung up. The motor crew contacted Perron and his partner in the stope and informed them of this. Perron was loading the breast in the shrinkage section of the stope and did not want the motor crew to blast the hung up chute because the resulting smoke would hinder him in lighting his shots. Instead, Perron climbed the manway beside No. 31 millhole, examined the hang up and tried to break it by prying with a bar. He was not successful and the chute was left hung up. Perron reported this to Shift Boss Cotnam when he reached surface at the end of the shift. Cotnam recorded the hang up in his report to the shift boss on the following shift.

Perron changed shift that night and returned to work at 7.00 A.M., on January 30. His partner of the night before did not change. Shift Boss William Watts read the note left by Cotnam regarding the hung up chute and gave Perron instructions not to go near it until it was blasted down and made safe to do so. At this time, Watts assigned Joseph Paquette to work with Perron as stope helper for the shift. Perron returned to the stope fully aware of the condition of No. 31 millhole. Paquette may or may not have been aware of the hang up at this time.

Shift Boss Watts also told the motor crew on his shift on 1850-foot level of the hung up millhole and instructed them to contact the stope crew (Perron and Paquette) and then to blast it down. The motor crew consisting of Antonas Margelis, motorman, and William McDonald, switchman, proceeded to do this. They blasted from the chute on the level but were not successful. Perron then went down to the level with Paquette, climbed the manway beside No. 31 millhole and blasted again. This time, the hang up broke and the muck over the millhole in the stope ran into it.

Perron and Paquette returned to the stope and went over the top of the millhole. About three-quarters of the top of the millhole was open with the muck in the pile from the stope drift standing more or less vertically on the far (east) side of it. The millhole was not full. Perron should then have followed instructions to







make the millhole safe by operating the slusher scraper to pull the steep muck pile down to fill it. The slusher and scraper were set up and he could have easily and safely done this. Instead, he climbed up the muck pile at the footwall side of the footwall side of the millhole and went into the stope drift to determine the results of the reblasting he had done there the night before. He did not give Paquette any instructions or warning regarding the millhole and while he was in the drift he could not see Paquette. No one witnessed the events that followed. Paquette might have tried to follow Perron and dislodged muck that ran and carried him into the millhole. He might have attempted to bar the steep muck pile down into the millhole, lost his balance and fell into it. In any event Perron heard the muck run and then heard Paquette shouting for help. Margelis and McDonald who were on the level pulling No. 31 chute heard the run of muck and heard Paquette shouting. They stopped pulling immediately.

Help was summoned and Paquette was rescued at about 3.15 P.M. through a hole cut in the timber separating the millhole and manway. He was able to talk to the rescue workers during most of the time. He died very shortly after being uncovered and before he was removed from the millhole. Dr. R. M. Bissonnette was at the scene of the accident for several hours prior to the rescue and up to the time of death.

An inquest was held before Coroner J. B. McClinton, M.D., in the Council Chamber of the Timmins Municipal Building on February 23, at 4.00 P.M. The jury returned the following verdict:

"We the jury find that Joseph Paquette came to his death January 30, 1960. We have found due to the fact of no eye witnesses Joseph Paquette working in 121 N. H. west of 11.3 Hollinger met his death accidentally with no blame attached to anyone."











DUO-TANG  
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